**ENP: Formulas for Health and Wellness**
**White House Conference on Aging Designated Event**

*Thursday, March 17, 2005*
Jean Mayer USDA Human Nutrition Research Center on Aging
711 Washington Street Boston, Massachusetts 02111

***Recommendation 1:***

Meal and Nutrition services are needed by elders in many and varied settings. The Nutrition Programs provided under the aegis of the Older Americans Act should be strengthened and renewed to best meet the future nutritional needs of the aged. Currently funding is only for meal services and need to be funded for nutrition service. Service may need to be funded based on the following needs

- Meal services
  –Congregate meals (low income, minorities)
  –Home delivered meals (oldest old, minority population, functional impairment, therapeutic needs)
- Nutrition services
  –Information and Referral (Boomer generation, younger old)
  –Comprehensive nutrition services/ Medical Nutrition Therapy (high risk population)

***Recommendation 2:***

Expand funding for federal and state nutrition services in home and community-based programs

- The Older Americans Act Nutrition Program
- Medicaid Home and Community based waiver program
- Caregiver Support Programs

***Recommendation 3:***

Require a full range review/evaluation by the Food and Nutrition Board of the Institute of Medicine (IOM) at the National Academy of Sciences toward ascertaining effectiveness of OAA Nutrition Programs in supporting successful health outcomes.

***Recommendation 4:***

Garner support for applied research on nutrition and aging

- Support a permanent center for Nutrition, Physical Activity and Aging include in the reauthorized law funded under OAA Title IV (the National Aging Nutrition and Wellness Research Center at Florida International University);
- Establish a national Aging Nutrition and Wellness Research center funded under OAA Title IV (USDA Human Nutrition center in Boston);
- Forge a partnership between the Public Health and Aging Services sectors; and
- Merge the purposes of the Health Promotion/Disease Prevention and Nutritional Programs within Title III of the OAA.

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Massachusetts Office of Elder Affairs
Massachusetts Meals on Wheels Association
Friedman School of Nutrition Science and Policy, Tufts University
USDA Human Nutrition Research Center on Aging

***Recommendation 1:***

**Meal and Nutrition services are needed by elders in many and varied settings. The Nutrition Programs provided under the aegis of the Older Americans Act should be reorganized and renewed to best meet the future nutritional needs of the aged.**

***Issues:***

A. Health Status: It has been estimated that by 2020, when baby boomers (born between the years 1946 and 1964) have reached age 65, the number of elderly will reach 71 million and equal nearly one third of America's population (1). The risk of disease and disability inevitably increases with age. It is well known that the majority of older adults (60 and older) experience one or more chronic diseases, and these diseases are often preventable (1). Moreover, studies have shown that older adults do not consume adequate amounts of dairy, grains, fruits and vegetables, which again leads to health problems that could be prevented with proper nutrition (2). The growing new generation of boomers and their prevalent health problems is another issue. Extra large portions of food and beverages, sedentary lifestyles and convenience foods are what they are accustomed to and, indeed, value (4). Obesity, diabetes, heart disease and cancer are the nutrition-preventable health problems expected to occur among the boomers (4). Due to improved health care system, there is also a rapid growth of people over 85+, which leads to nutrition requirements that are sensitive to the needs of disabled and frail elders.

B. Differing Needs: The original purpose of the Older American Act (OAA) Nutrition Programs was to address dietary inadequacy and social isolation among older adults. According to Millen et al study (3) that needs remains, however, nutrition programs are now confronted with another dilemma. On one end of the spectrum, they are challenged with serving an increasing number of frailer, cultural diversity, functionally impaired, and disabled older adults (as evidenced by the growing demand for home delivered meals), while on the other is the growing "younger- old" adults population, the baby boomers. With demographic changes in elder populations, the nutrition needs change too. The 1993-1995 Millen study showed that OAA Nutrition Programs clients are 90% low income and minority, that the nutrition programs provide 40-50% of the participants' daily intake, and that participants had 14 to 15 more social contacts. Although food and nutrition services are currently provided to older adults through health care and social support systems, these services are not universal. In addition, these parallel yet separate systems do not assure continuity of care.

C. Meet White House Conference on Aging Annotated Agenda: A Hybrid Model of services is needed, one that combines the characteristics of the community and medical models. The community model includes services such as transportation, meal programs, home care, and home health and does not provide therapeutic services. The medical model includes services such as nursing homes, inpatient rehabilitation, PCA, hospice, medical supplies, etc.

***Barriers***:

Policy design can operate as a barrier as only active participants in congregate or home delivered meal programs are allowed access to the full continuum of OAA programs. Also, establishment of a Hybrid model of services requires new funding as it necessitates additional employees, training, space, time, and materials. The philosophy of purpose of OAA Nutrition Programs is another barrier, as they are perceived as social and food assistance programs. This thinking may interfere in the Hybrid Model of services establishment, wherein medical and community models merge.

***Solutions:***

To have the range of services that a Hybrid Model represents as it combines the characteristics of a community model and medical model and will meet the needs of a range of populations. Medicaid Waiver coverage of OAA Nutrition Programs services will aid in the process of combining two models to create one toward establishment of a comprehensive nutrition program. Finally, nutrition services must be provided to meet the following needs and purposes:

- Congregate meals (predominantly targeted to low income, minorities)
- Home delivered meals (oldest old, minority populations, and functional impairments)
- Information and Referral (Boomer generation, younger old)
- Comprehensive nutrition services (high risk populations)
- Medical Nutrition Therapy (MNT)

Moreover, public and private initiatives are needed to improve the safety net for nutrition among the nation's older adults. Government, academia, the health care community, civic and religious institutions and individuals all have roles to play in assuring that older adults' nutritional needs are met. Support and coordination of activities and partnerships are vital if improvements are to be realized and sustained.

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***Recommendation 2:***

**Expand funding for federal and state nutrition services in home and community-based programs, such as the Older Americans Act Nutrition Program, Medicaid Waiver and Caregiver Support Programs.**

***Issues:***

OAA Nutrition Programs provide services to frail, homebound and disabled elders. The majority of homebound elders in the OAA nutrition program are primarily low income, and thus eligible for Medicaid services. The bulk of this population is at a high nutrition risk, at roughly the same rate as hospital and long term care populations (3). Evidence-based research has proven that preventive services (using the primary and secondary disease prevention approaches) are cost effective and efficacious. Also, homebound elders not enrolled in any OAA Nutrition Program also suffer by virtue of not having access to the broader range of nutritional services. Integrating Medical Nutrition Therapy within all health care delivery systems serving older adults will yield substantial savings in other areas. Reimbursement for MNT services directed toward unintended weight loss, dehydration and wounds would mean more older adults could obtain these services. OAA programs provide not only nutritious meals but also nutrition services such as nutrition screening, nutrition education, nutrition counseling, MNT and follow-up/intervention. However, it is necessary to provide a continuum of these services to promote health and well being, prevent disease and its complications, and improve the management of health-related problems in older Americans. Another issue that interferes with provision of the above mentioned services is funding. Currently, funding through a Medicaid Waiver pays for the following in-home services: case management, case aide, companion, attendant, chore, medical supplies, counseling, environmental accessibility adaptations (ramps, grab bars, etc.), escort, family training, health support, home-delivered meals, homemaker, personal care services, personal emergency response systems, pest control, risk reduction, respite care, skilled nursing, specialized medical equipment, physical, occupational, and speech therapy, but neglect medical foods and nutritional services. Food and nutrition services are simply overlooked by states' Medicaid Waiver programs while other services are covered automatically.

***Barriers:***

Nutrition services are not provided to all American elders. Older adults, receiving home or community-based programs do not necessarily receive nutrition services. Therefore, Older American Nutrition Programs are hindered in attempts to serve the growing needs of an increasing frail population. Moreover, the boomer generation needing primary and secondary disease prevention often can not receive proper nutritional services due to restrictions placed on treatment and services by third party payers. Again, Medicaid Waiver services include many specific in-home and community-based services as a matter of course. Nutrition services, however, are not approved for federal coverage in most states and hence are not covered by the Medicaid Waiver program. Finally, OAA has no particular language requiring a dietitian to perform MNT.

***Solutions:***

Health professionals concur that good nutritional status keeps people healthy and independent, leads to shorter stays in hospital and prevents placements in costly nursing homes, and promotes faster recovery from illness/injury with fewer costly complications. A Medicaid Waiver program represents an opportunity for OAA Nutrition Programs to increase the number of services they provide. The waiver should mandate payment for nutrition services and make the Older American Act Nutrition Programs the main element for delivery of nutritional support services to elders in their homes and their communities. Finally, Registered Dietitians and other health professionals should be trained to obtain reimbursement for MNT services through Medicare.

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***Recommendation 3:***

**Require a full range review/evaluation by the Institute of Medicine (IOM) at the National Academy of Sciences toward ascertaining effectiveness of OAA Nutrition Programs in supporting successful health outcomes.**

***Issue:***

The IOM of the National Academies advises national health leaders on matters of biomedical sciences, medicine and public health. The institute provides unbiased, evidence based, and authoritative information (7). The IOM's committee evaluation framework includes four components: principles, planning processes, evaluation elements, and evaluation questions. IOM methodology calls for use of each of these principles in this analysis and that they be:

- Incorporated from the start of project planning;
- Viewed as a cumulative process of building knowledge, not as an isolated effort;
- Organized around comparisons with the benefits and costs of relevant health care alternatives
- Aimed at identifying practical, affordable, and sustainable applications

Older American Nutrition Program is the only federal nutrition program that have never been reviewed by an objective, expert committee at the IOM. An IOM evaluation will enable nutrition programs to recognize areas that need higher refinement toward maximum effectiveness. Also, it would illuminate whether Older Americans Act Nutrition Program meets current population needs. Further, the IOM evaluation will identify more cost effective ways to carry out all aspects and operations of the Older American Nutrition Program.

***Barrier:***

Lack of evaluation of the Older Americans Act Nutrition Programs health outcomes leads to biased and unreliable data. Evaluation of health outcomes is needed to validate the importance of the existing data.

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***Recommendation 4:***

**Garner support for applied research on nutrition and aging, establish a National Aging Nutrition and Wellness Research Center, forge a partnership between the Public Health and Aging Services sectors, and merge the purposes of the Health Promotion/Disease Prevention and Nutritional Programs within Title III of the OAA.**

***Issues:***

There is clear evidence documenting the effectiveness of nutritional strategies in preventing or mitigating diseases such as diabetes, hypertension, CAD and osteoporosis, however there is a lack of evidence on what role nutritional programs play in any given population in matters of disease prevention. Of course, chronic disease is high among elderly populations, and applied nutrition and aging research is needed to determine the nutritional needs and optimal diets in nursing homes, for the homebound and for the very old. Outcomes research will verify the manners in which dietetic professionals influence positive clinical and quality of life outcomes in Long Term Care, home health, and community programs. Finally, funding is required to develop instruments such as nutrition assessment criteria, a nutrition risk assessment tool and to develop a nutrition quality of life measurement tool.

***Barrier:***

Funding is the central barrier in establishing and operating both health promotion and disease prevention programs that combine nutrition services in their operation. Also, until now, there has been no mandate within the OAA for marrying evidence-based health promotion and disease prevention programs with a nutritional component.

***Solution:***

The above barriers could be easily mitigated when collaboration between the Public Health network and Aging agencies network is established, as well as when an Aging Nutrition and Wellness Research Center is instituted. A partnership between the Public Health and Aging services networks is a way to mutually benefit both systems. In a collaborative model redundancy can be minimized, while resources and funding can be combined toward the same objectives. Also, the Aging Nutrition and Wellness Research Center would supply OAA with current data and resources and support the Aging Policy Resource Center. Finally, the purposes and resources represented by Title III-D of the Older American Act, Health Promotion and Disease Prevention, should be combined with OAA Nutrition Programs. The methods and goals of these two currently separate efforts are mutually supportive and naturally complementary and maximum effectiveness would be achieved by aligning the two structures.

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